Political challenges facing the consolidation of the Sistema Único de Saúde: a historical approach

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Abstract

This article investigates the circumstances in which Brazil's sanitation reform was conceived and the Sistema Único de Saúde (SUS) was constructed. A brief analysis is conducted of Brazil's political transition to democracy, focusing on three political challenges facing the consolidation of SUS: its weak support base amongst workers, competition with the private sector, and the fragmentation of its administration caused by its municipalization. Finally, the changes in the scenario caused by the weakening of neoliberalism since the 2008 crisis, the reemergence of a multipolar political scenario internationally, and the financing conditions of the Brazilian State are described.

Keywords: health system; Sistema Único de Saúde (SUS); social policies; decentralization; private sector.

The creation of the Unified Health System (Sistema Único de Saúde, SUS) by the 1988 Constitution was part of a broader process of change in the political relationship between state and society in Brazil, enabling health to be acknowledged as a social right addressed in public policies according to the social democratic model, the most widespread form of welfare state according to Esping-Andersen's typology (1990).[1] In fact, all Brazil's social policies, not just its health policies, were defined according to this model, based on the recognition of its citizens' rights and the State's duty to provide for them (Rodrigues, Kornis, 1999). However, this change took place under very specific, challenging, historical circumstances which had a huge influence on its introduction and imposed restrictions and limits on SUS which have yet to be overcome and for which a high price is still paid.

As this article focuses on the introduction of sanitation reforms, the analysis is limited to health policies and makes only passing reference to other social policies as and when necessary. As the idea was primarily to cover the political aspects of the process, some key elements are not analyzed, such as the serious shortfalls in the financing of the system or the management difficulties, mostly derived from the intentional weakening of public administration inherent to the neoliberal political policies adopted in recent decades. At the time of writing, two questions concerning these issues were particularly in the public eye. The first had to do with the difficulty in getting the People's Proposal (complementary bill no.321/2013) passed, designed to guarantee the effective, full pass-through of 10% of the Union's current gross revenues to SUS, also known as "Health + 10" (Carvalho, 26 nov. 2013). The second was the rise in the adoption of private management methods within the system, such as social organizations, private foundations providing public services, and Empresa Brasileira de Serviços Hospitalares (a government company responsible for managing federal university hospitals). As financial and managerial matters are not the focus of this article, they are mentioned in the text only with the purpose of illustrating or reinforcing the arguments concerning the political process by which SUS was conceived and constructed.

The first political aspect to be addressed has to do with the fact that Brazil started to implement rights and services of a social democratic nature under unfavorable circumstances, dominated both nationally and internationally by neoliberal ideas and practices. This hampered the development of new social policies in many ways, and over the years it has increasingly raised dilemmas about how to maintain the social democratic model conceived for the policies, as set forth in the Constitution. In the second half of the 1990s, for instance, the Fernando Henrique Cardoso administration began introducing focal policies that were clearly rooted in the neoliberal model proposed by the World Bank. These policies were not only continued during the Luiz Inácio Lula da Silva administration, but were actually fortified and expanded.

The second political circumstance that affected the construction of SUS and still hampers its consolidation arises from the weakness of its support base amongst workers, particularly labor unions. Unlike in other countries around the world, whose social democratic public health systems enjoy the broad support of workers through the political parties and workers' organizations that represent them, in Brazil several measures taken by the military regime, to be discussed in greater depth later, gradually fostered a political and ideological divide

between organized workers and the public health system. This restricted the support base for SUS in society, especially urban social movements, organizations representing people with specific diseases, and higher education professionals working in the area of health. Most workers and their unions in Brazil have been attracted by private health insurance schemes, and since as far back as the 1970s unions have been fighting for broader access to the services they provide.

The weakness of the support base for the public health system is associated with another historical circumstance: the existence in Brazil of one of the largest private health sectors in the whole world.[2] When the military took power, the private sector was boosted by countless policies designed to strengthen it, and these policies were not reverted when SUS was created. The manner and speed with which the private health sector has grown in Brazil has made it a powerful rival for the public health system, both for financial and human resources and for the hearts and minds of the vast majority of the population. Private health insurance providers account for a significant share of the market. In 2010, 45 million individuals out of the total Brazilian population of 190 million had private health insurance, or about 24% (ANS, s.d.b; Brasil, s.d.a); and this in one of the countries with the highest rates of social and economic inequality in the world. It would also be fair to say that most Brazilians who do not have access to private healthcare aspire to it; a survey published recently in the press found that 90% of Brazilian workers would like to have private health insurance, putting this "benefit" first on their wish list (Scheller, 6 jun. 2011). This also reveals how poorly the public health system is seen by the population.

Another historical circumstance that has hampered SUS is the decentralization of its administration to the municipal level. This, the only case of its kind in the whole world, has to do with certain features of the Brazilian political and electoral system, whose origins date back to the local councils during colonial times, which guaranteed the private sector, constituted primarily of landowners and merchants, control of local government. These founding features were subsequently reinforced by the electoral reforms made during the Ernesto Geisel administration (1974-1979) with the purpose of curbing opposition and bolstering conservative interests, and were not altered after the return to democracy. One of the main outcomes of having public healthcare services run at municipal level is that to this day, SUS does not work effectively as an integrated, regionalized system as envisaged in article 198, item II of the Constitution (Constituição, 2011) and article 7, items II and IX, sub-item b of the Organic Law for Health (Brasil, 1990).

In this paper are examined some of the political circumstances that affected the processes by which SUS was conceived and constituted as of the 1980s, beginning with a brief analysis of the profound changes in the international and national scenario brought about by the global rise of neoliberal ideologies and the attempt of the USA to limit the expansion of socialism. These changes inverted the general meaning of capitalist development agreed in 1944 at Bretton Woods, and in Brazil they went towards replacing national developmentalism, which had dominated Brazilian politics since the 1930s, with new concepts in which neoliberal ideas and regional interests prevailed.

The testing circumstances in which the Sistema Único de Saúde emerged: headwinds in the international scenario

The international scenario in which Brazil chose to adopt a broad social rights policy, including health, was characterized by a number of dramatic events that have had a significant impact on recent world history and also on Brazil. The first of these was political in nature: the rise of neoliberalism as a dominant political ideology in central countries like the USA and Great Britain. The change came first in the UK in 1979 with the election of Margaret Thatcher (Fiori, 1997, p.115; Judt, 2008, p.541), and subsequently in 1980 when Ronald Reagan was elected president of the USA (Hobsbawn, 1995, p.244). These elections triggered the start of at least three decades of reversion of Keynesian policies, which had guaranteed both strong economic growth and the adoption in most central capitalist countries of a number of social protection policies known as the welfare state (Esping-Andersen, 1990). With the election of these two leaders, both countries and the main international agencies created by the Bretton Woods Conference in 1944 (Lichtesztejn, Baer, 1987, p.28; Helleiner, 1997, p.164) – the International Monetary Fund (IMF) and the World Bank – started to adopt economic policies geared towards greater market freedoms, defined by authors like Friedrich Hayek, Milton Friedman and Ludwig von Mises, founders of the Mont Pèlerin Society, created in Switzerland in 1947 (Anderson, 1995, p.9-10), to oppose state intervention in the economy, which had been allowed and even encouraged by the Bretton Woods agreement.

Economically speaking, the second half of the 1970s marked the end of a period of intense growth that had started after the end of the Second World War, which Hobsbawn (1995) called the "golden age of capitalism." There were also the two oil shocks in 1973 and 1979 which pushed up the cost of energy and international interest rates, triggering foreign debt crises in many countries, Brazil included. The event that most marked the change in economic direction that decade was without doubt the adoption by the US Federal Reserve, then under the chairmanship of Paul Volcker, of high interest rates on US Treasury bonds as of January 1979 (Torres Filho, 1997, p.387; Ferguson, 2007, p.222). According to Chesnais (2005, p.40), interest on the country's public debt increased three or fourfold between 1979 and 1981.

This abrupt interest rate hike triggered a widespread foreign debt crisis which affected most countries in Latin America and the Soviet bloc in Eastern Europe as of the 1980s. Its first victim was Mexico, which declared a moratorium on its debt in 1982 (Chesnais, 2005, p.40). The rise in interest rates on the international market prompted the mass transfer of funds from these regions to the creditor countries at the heart of the capitalist system, especially the US, causing countless economic and financial problems for the indebted nations. As their foreign debts swelled, they were forced to take out new loans in order to pay the interest on their initial debts. Swamped by combined exchange rate and fiscal crises, the countries gradually submitted, one after the other, to structural adjustments that limited their sovereignty and curbed investments in their economies (Fiori, 1997; Ferguson, 2009). This structural adjustment policy was launched in 1984 with the Baker Plan, which, by redefining the roles of the IMF and the World Bank, made them its instruments (Gowan, 2003, p.62, 76).

The aims of this policy were not just economic; they were part of a broader set of initiatives that encompassed economic, political and military fields in a phenomenon Maria da

Conceição Tavares (1997) called the "reassertion of US hegemony." Through this process the USA sought to revert the relative political and economic decline it had experienced since the 1970s, when it had lost the Vietnam War and also its main ally in the Persian Gulf, the Shah Pahlavi regime in Iran, not to mention other smaller upsets, such as the revolution in Nicaragua and the alignment of former Portuguese African colonies with the socialist bloc. Military spending on the wars in Korea and Vietnam, plus the higher cost of oil, which it now imported on a large scale, started to weigh heavily on the finances of the North American giant, marked by the "dual deficit" of its public budget and balance of payments (Chesnais, 1996, p.250; Tavares, 1997).

In an attempt to revert this troublesome scenario, the Reagan government took a variety of measures on the political front. In 1983 it set into action the Strategic Defense Initiative, better known as Star Wars, thereby forcing the USSR to boost its own military spending, which peaked at 15% of its GDP (Oliveira, 2012, p.90). In the same year, US forces invaded Granada, a practical demonstration that the Reagan Doctrine was more than mere words; this doctrine had been devised by Jeane Kirkpatrick, international policy advisor at the State Department, and proposed actively curbing Soviet advances around the world. Along the same lines, in 1986 the US struck Libya by air and sea (Hobsbawn, 1995, p.244; Ferguson, 2011, p.182), and in 1988 they invaded Panama with 27,000 marines, who tracked down and detained the president, Manuel Noriega, under charges of corruption and drug trafficking (Losurdo, 2009, p.39). One year earlier, heartened by the weakening of several communist countries in Europe, Reagan had already openly demanded, as he stood in front of the Brandenburg Gate, that Gorbachev open the gate and tear down the Berlin Wall (Brown, 2010, p.554). These actions, combined with the weakening of the socialist bloc in Europe, did indeed result, on June 4, 1989, in the fall of the Berlin Wall, the ultimate symbol of the socialist experiment in Europe (Johnson, 2007, p.27), followed in 1991 by the crumbling of the USSR (Hosking, 2002, p.595). The European socialist bloc had come to an end and with it the Cold War.

This represented an about-turn not just in the social, economic and ideological course taken since 1945, but also in the building of the socialist experience in Europe, starting with the Soviet Revolution of 1917. With the Cold War over, the political and ideological disputes between the two blocs came to an end, leaving the USA as the world's only real military and economic powerhouse, a vindication of the "reassertion of US hegemony" policy, at least in its first phase. This policy also imposed a new international division of labor on so-called developing countries, brought about by structural changes which determined the opening of their markets, acceptance of the minimal state, and privatization of their state-owned assets in order to cover their foreign debts, which had been inflated by the Federal Reserve's high interest rate policy (Tavares, 1997).

Apparently there could be no more unfavorable international circumstances for the social justice project embedded in title VIII of the 1988 Brazilian Constitution, covering social order and establishing universal social rights for social welfare, education, healthcare and social security. Social security, despite being contribution-based, contained a clearly universalizing element[3], as shown by Matisjacic (2002). A number of circumstances affecting the national sphere also clearly hampered the new social policies, as we will see in the next section.

Contradictions on the home front

Brazil's debt crisis, which began in the early 1980s, sparked changes that simultaneously accelerated the transition from the military regime to democracy, put an end to the national developmentalism that had prevailed, one way or another, from 1930 to 1980 (Sallum Jr., 1994, p.149; Bresser-Pereira, 2010, p.3), and created hardships of a financial and economic nature and also guidelines for the implementation of the social democratic policies established by the 1988 Constitution. As the return to democracy gained pace, popular movements were given greater involvement in shaping the country's future, while state social spending and policies were expanded. There were therefore many contradictory forces at play which provided unprecedented potential for Brazil to overcome its historical social inequalities, despite the serious limitations and difficulties imposed.

The signing of an agreement with the IMF in February 1983 obliged the country to confront the economic crisis along neoliberal lines: liberalizing the economy, slashing public spending, and putting an end to national developmentalism (Belluzzo, 1984, p.163; Sallum Jr., 1994, p.154). The agreement was designed to address Brazil's foreign debt, the servicing of which had risen from four hundred million dollars a year in 1970 to eight billion in 1982 (Gonçalves, Pomar, 2002, p.48). Meanwhile, the principal leapt from 12.5 billion dollars in 1973 to 49.9 billion dollars in 1979 (Bandeira, 2011, p.212). The debt peaked in 1987 at 107 billion dollars; a moratorium on its payment was declared in February of the same year by the José Sarney government (Bandeira, 2011, p.245-246).

This structural adjustment instantly put an end to the national development policies which, since the 1930s, had sought to build a relatively autonomous form of industrial capitalism, and a "slow, steady, safe" transition to democracy initiated under President Geisel (Sallum Jr., 1994). The reduction in investments and restrictions on wage increases and new public sector hirings, even for state-owned companies, displeased a good part of the regime's social and political support base, especially sectors of private industry and urban middle classes with jobs in the civil service and state-owned companies. Social discontent with the structural adjustment was a key factor in the mass movement for political "rights now", which started in the early months of 1984 and accelerated the political transition (Sallum Jr., 1994, 2003; Couto, 1997; Arturi, nov. 2001). Although the movement did not achieve its main goal – direct elections for the president of the republic – it did prevent Paulo Maluf from being officially named as a presidential candidate as it attracted key political figures from the Aliança Renovadora Nacional (Arena) party, including Antonio Carlos Magalhães, Aureliano Chaves, José Sarney and Marco Maciel, who distanced themselves from the regime and supported the opposition candidate, Tancredo Neves (Sallum Jr., 1994).

The political transition effectively accelerated the end of the military regime and put an end to the political domination of national developmentalism which had limited the participation of the masses in the political process, giving them greater autonomy and voice, and making way for the social democratic social policies introduced in the 1988 Constitution. The way this political transition took place also gave rise to a new government pact, replacing national developmentalism with neoliberal concepts. The incorporation of a broader set of forces, including sectors that had supported the military, the distortion of electoral representation

between different regions of the country, and the enablement of political dispersion into multiple parties helped strengthen traditional conservative forces and restrict the reach of social change (Couto, 1997; Sallum Jr., 2003; Arretche, Rodden, 2004). Illustrative of the presence of conservative forces in the new political pact were both the formation of the "big center" (*centrão*) during the drafting of the constitution and its involvement in the many coalitions needed to support the Fernando Henrique Cardoso, Luiz Inácio Lula da Silva and Dilma Rousseff governments. These broad coalitions effectively dilute the governing parties' programs and charge a high price when it comes to choosing the leading positions in the government, not to mention forced budget amendments and frequent cases of corruption (Arretche, Rodden, 2004; Sadek, 1993). The very process of drafting the constitution, made by a constituent Congress rather than a Constituent Assembly elected specially for the purpose, contributed, among other things, to the maintenance of the electoral rules imposed by the package of laws passed in April 1977 (Mota, s.d.).

These rules inflate the representation of states with a smaller constituency where oligarchs and conservative interests have traditionally prevailed, to the detriment of more highly populated, built-up areas. In other words, while just nine thousand votes are needed to elect a congressman in the state of Roraima, around 308,000 are needed for one congressman in São Paulo (Sadek, 1993, p.12). The April 1977 laws, which were passed with the intention of weakening the Movimento Democrático Brasileiro (MDB), which was gaining ground on the pro-military Arena party, also facilitated the proliferation of political parties.[4] The sheer number of parties that existed after the return to democracy formed the basis for what Sérgio Abranches (1988) called "coalition presidentialism", referring to the difficulty of forming a majority in the legislature, such that alliances with an ever greater number of political parties have to be forged, resulting in the dilution of the programs intended by the party of the elected president, and more power for conservative forces within governments (Limongi, Figueiredo, 1998; Arretche, Rodden, 2004; Sodré, Alves, 2010). These features of the Brazilian political and electoral system help explain how change in the country has been limited and give an understanding of why, upon creating SUS, the 1988 Constitution also maintained a large private healthcare system to compete with it, counting on all the fiscal privileges it had had since the military regime, a rare state of affairs in countries that create public, universal health systems (Rodrigues, Santos, 2011).

Despite the frankly unfavorable circumstances in the international and national scenario, the 1988 decision for universal social policies and the creation of a public health system for all triggered the start of major change in Brazil's social history. Indeed, Gouveia and Palma (1999) claim that the process by which SUS was created went counter to the ideas of neoliberalism, and attribute the process an almost epic nature. What I wish to stress here is that these adverse factors were so detrimental that the restrictions and challenges they imposed have yet to be overcome, to the point of potentially jeopardizing the survival of the Brazilian public health system, or at least of marginalizing it exclusively towards the poorest sectors of society. These challenges have to do with its fragile support base in society, unfair competition from the private or "supplementary" healthcare system, and SUS's political fragmentation into thousands of municipal authorities, most of which are unequipped or uninterested in organizing a network of healthcare services in line with the principles and guidelines of SUS.

Another factor worth remembering when considering the circumstances in which the 1988 Constitution was written is that the debt crisis took place just one year before it was passed. With a new liberal pact in place after the election of Fernando Collor de Mello in 1989, the 1990s heralded the elimination of mechanisms designed to protect the domestic market – licenses, non-tariff barriers, protectionist tariffs –, not to mention a number of measures that restricted economic growth (Sallum Jr., 2003). Inspired by neoliberal ideas, the government introduced economic measures such as opening the country to foreign trade and finance, privatizations, and strict monetary control. As for SUS, Collor vetoed several articles from the Organic Law for Health (Viana, 1995) and drastically reduced its federal funding, which, by 1993, had dropped to about half the level seen during the Sarney government (Levcovitz, 1997, p.200). As for the share of federal revenues that were geared towards health spending, this proportion dropped from 18.9% in 1989 to 9.1% in 1993, the last year of the Collor administration (Levcovitz, 1997, p.164). This trend did not stop when he left power, because although federal health spending did rise initially under Itamar Franco, it was again hit when the social security system faced financial difficulties in 1993 (Levcovitz, 1997, p.164). The fact is that ever since it was created, SUS has suffered from underfunding (Carvalho, 2002), and as of the second half of the 1990 it was also competing increasingly for federal funding with targeted social policies, such as the Family Grant (Bolsa Família) program and social or racial quotas for entry to higher education.

In fact, according to National Treasury data, from 2000 to 2011, despite the fact that total federal spending on the social functions of government[5] increased at a higher pace than its spending on non-social functions (197.9% vs. 152.5% after inflation adjustments and financial expenses), the proportion of spending on health compared to total social spending dropped 22.5% from 14.7% to 11.4%. Meanwhile, the social welfare budget, encompassing the main targeted programs such as Bolsa Família, grew by 504.1%, such that expenditure in this area rose from 21.9% of health spending in 2000 (R$9.98 billion vis-à-vis R$45.55 billion) to 72% of health spending in 2011 (R$50.31 billion vis-à-vis R$69.86 billion) (Brasil, s.d.c). What is yet to be seen is whether the priority given to targeted programs, which were effective in reducing abject poverty, will successfully eliminate poverty and not hamper the development of social policies for all, such as SUS.

Trade unions caught between public and private health systems

The role of social movements in general and organized workers' movements in particular in the sanitation reform has been little explored by scholars investigating public health and the history of SUS (Souza, jun. 1990; Stotz, 1994). Few studies have gone into the subject in detail, the book by Sílvia Gerschman (1995) entitled *A democracia inconclusa: um estudo da reforma sanitária brasileira* (Unfinished democracy: a study of the Brazilian sanitation reform) being one of the rare exceptions. However, there are those who have drawn attention to the weakness of the support base for SUS amongst trade unions in Brazil as compared to the circumstances in which other public health systems have been introduced (Menicucci, 2003; Gerschman, Santos, 2006; Arretche, 2005). A more definitive explanation for the weakness of this support for SUS amongst organized workers'

movements requires greater investigation, but some important clues concerning this matter may be found in the existing literature both in the area of public health and in history and political science.

One of these has to do with the gradual distancing of urban workers from public healthcare services since the creation in the 1960s by the military government of the National Social Security Institute (Instituto Nacional de Previdência Social, INPS). The unification of the existing social welfare corporate entities had two immediate consequences for city workers and their relationship with the public health system. The first was their loss of representation in the leadership of the new body responsible for healthcare and welfare policies, as compared with the former Pension Institutes (Institutos de Aposentadorias e Pensões, IAPs). The second was that they had to fight for access to a social welfare – and healthcare – system that was taking new social groups under its wing, rather than enjoying the benefits of being customers of units exclusively serving the economic groups they belonged to. This seems to have fostered growing dissatisfaction amongst workers at the public health system, making them more likely to be attracted by the rising private health insurance market (Arretche, 2005; Gerschman, Santos, 2006), which was bolstered by incentives supplied by the military regime, such as tax subsidies, priority in the contracting of services, and low-interest loans for the construction and reform of healthcare services (Cordeiro, 1984; Braga, Paula, 1986; Levcovitz, 1997).

This growing distancing of organized workers from public healthcare services was also motivated by actions taken by the military against the main left-wing groups in Brazil which had led the trade unions before the military coup and in the first years of the dictatorship: the Partido Comunista Brasileiro (PCB) and the Partido Trabalhista Brasileiro (PTB). The PCB, which had organized peaceful, democratic resistance to the regime, was the target of a serious crack-down during the two years of "Operation Radar", starting in 1974, resulting in the assassination of 12 of its leaders and the imprisonment of over six hundred of its activists (Gorender, 1987, p.232-233; Mir, 2007, p.321-323; Silva, 2009, p.265). This blow against the main communist organization was devastating, and severely affected its capacity to act in the future, although the PCB did still have the power to take on some more important roles, and was a key player in the sanitation reform in the late 1980s (Cohn, 2008, p.202; Escorel, 1998). The most important splinter group from the PCB, called the Partido Comunista do Brasil (PCdoB), which adopted guerilla tactics between 1972 and 1975 in the Araguaia region, also saw its leaders massacred in December 1976 during an army operation in the Lapa district of São Paulo (Pomar, 2006, p.17; Silva, 2009, p.266).

As of 1974, the labor leaders still active in the trade unions also suffered political persecution in much the same way that the communist leaders had. Also, on September 15, 1977, João Goulart's successor as the leader of *trabalhismo* (political and labor movement organized around the PTB), Leonel de Moura Brizola, who had been living in exile in Uruguay, was ordered to leave the country after the Brazilian military exerted pressure on the Uruguayan military regime (Bandeira, 2010, p.21). Brizola continued to lead the *trabalhistas* (PTB militants) acting in clandestinity, but now from even further away, in the USA. The prestige of the PTB acronym and its nationalistic appeal were still intact amongst those who had been active by his side or shared his views (Mir, 2007, p.336). Based on this support

and the historical struggles of the party, Brizola obtained, in 1979 in Vienna, by a unanimous vote, the recognition of the PTB as a legitimate representative of Socialist International in Brazil, beating the rival candidature supported by Fernando Henrique Cardoso and José Serra (Mir, 2007, p.333, 334). In 1979, a political amnesty enabled Brizola to return to Brazil, bringing with him the assurance of support from historical workers' movements and international prestige. However, in 1980 the PTB name was ultimately granted by the regime to Ivete Vargas and not to Brizola, its main leader (Schmitt, 2000). Despite the rift in the labor movement, Brizola's followers had to rally round a new acronym, PDT (Partido Democrático Trabalhista), which bore no ties to their important political past (Mir, 2007, p.333, Aquino et al., 2001, p.773).

With Brazil's main left-wing groups weakened, it became easier the strenghthening of the Partido dos Trabalhadores (PT), created in 1980, which had quite different social and ideological bases from the parties that had thus far represented the left in Brazil (PCB and PTB). Although it attracted former activists from communist and social-democratic organizations, PT counted on its strongest social base amongst grassroots Catholic ecclesiastical communities and workers from ABC Paulista (São Paulo industrial area), who had reorganized themselves in the second half of the 1970s, when the communist and *trabalhista* movements had lost much of their influence in the region (Mir, 2007). It may be said, then, that from the perspective of left-wing politics, Brazil's social movement underwent a major break with its past thanks to deliberate political measures taken by the military dictatorship in its final years. This had a powerful impact on the sanitation reform process, removing workers and unions from its support base in society, which, rather than adding their voices to the calls for public health, put their efforts into obtaining access to private health insurance schemes via collective bargaining with business leaders.

There were important leaders and groups within PT who not just defended but also participated actively in the construction of SUS, many taking on leadership roles in the management of the system in the three spheres of government, while also lobbying the councils and forums in different spheres of government designed to oversee the execution of public policies. Certain key institutional innovations in the management of SUS were introduced thanks to some sectors of PT. Meanwhile, however, its trade union leaders have kept a certain distance from the public health system, even if their discourse towards it is positive. These leaders, the leaders of the main trade union federation linked to the party, Central Única dos Trabalhadores (CUT), and leaders of other unions have been struggling to broaden workers' access to private health insurance in practically all collective bargaining. Getting these leaders to consistently support the consolidation of SUS remains one of the biggest hurdles blocking the political future of the system to this day.

Another explanation for the distancing of organized workers from public health draws attention to the fact that the corporate format of the social policies that prevailed until the creation of INPS, and which lasted over thirty years, was propitious for the formation not of a shared ideology or class solidarity between workers, but of a segmented ideology, as it separated workers into different professional categories, which did anything but help foster political support for a universal health system. Furthermore, healthcare was organized in

such a way by the former social security institutes (IAPs) that urban workers were used to receiving private healthcare services, which also tended to bolster their support for private healthcare rather than public (Menicucci, 2003; Santos, 2009).

The influence of the private healthcare sector is another important element behind the relative distance of organized workers from SUS. Its pace of growth, especially with the military in power, enabled it to develop enough clout to compete with the public healthcare service for the hearts and minds of the different sectors of Brazilian society. Although the influence of private healthcare does not fall within the scope of this article, it is important to stress that its rapid growth was clearly supported by public policies conceived during the military regime, and was therefore not the result of natural market growth.

The development of private healthcare and its growing capacity to attract trade unions is a topic that still requires more specific investigation, but it is certainly strongly related to the distancing of organized workers from SUS. The elements raised here suggest that organized workers' attraction to the private health sector and its growth were the result of the same process of social construction as the private healthcare sector, in which the state played a decisive role, especially during the military dictatorship. Meanwhile, its continuation after the return to democracy and the choice of society for a public health system has to do with the national and international historical scenario in which the Brazilian sanitation reform took place.

Development of the private health sector and its increasing competition with the Sistema Único de Saúde

The relationships between the private healthcare market and the public health system are complex and involve diverse factors. Almost three decades ago, Hesio Cordeiro (1984) was already using the concept of a "medical-business complex" to try to explain the complex relationships arising from the penetration of capitalist relations in medical practice. The concept of the "medical-industrial complex" has also been used since the 1980s to explain the relationships between healthcare and industry, with its production of health equipment and inputs. Meanwhile, Vianna (2002) proposes the concept of the "medical-financial complex" to explain the growing penetration of financial capital in the health sector.

The scope of this article covers only the relationship between the public and private health systems concerning healthcare and the sale and management of private health insurance, or "private health plans" as they tend to be called in the literature and in Brazilian legislation, an approach that arises from the fact that competition between the two systems is emphasized as a function of the size of the private system in Brazil.

Since the 1920s, when the first pension funds (Caixas de Aposentadoria e Pensão) were created under the Eloy Chaves Law (decree-law no.4,682/1923), private healthcare providers were closely and increasingly associated with the healthcare services provided via the public welfare system. As of the creation of the pension associations (IAPs) (the first in June 1933 for sailors), the expansion of healthcare provided by the public welfare system resulted in the hiring of more private healthcare services (Oliveira, Teixeira, 1986). Things did not change when the military regime brought the IAPs under the umbrella of INPS; in fact, from then

on the public sector took a number of initiatives that strengthened the private sector, as briefly described below.

In 1966, not long after the military took power, a new national tax law was passed that granted the sector an important tax break: reduced income tax on private healthcare and health insurance services (Levcovitz, 1997, p.29). This incentive was maintained in the 1988 Constitution and continues to this day. The military government also encouraged from the outset the systematic use of third-party services for healthcare when it gave priority to hiring private services to enable the expansion of the public healthcare network established by decree-law 200 in 1967 (Luz, 1979, p.58; Cordeiro, 1984, p.56) and reinforced in 1974 by the Social Security Action Plan (Cordeiro, 1984, p.49). From then on, the military government also supplied subsidized loans to private healthcare providers using monies from the Social Development Support Fund (Braga, Paula, 1986, p.125). These incentives fostered a huge expansion of the private sector, as shown, for instance, by the growth of for-profit private healthcare units, which rose from 14.4% of total healthcare services in 1960 to 45.2% in 1975 (Braga, Paula, 1986, p.110).

Private healthcare providers were not the only ones to benefit from public sector actions. As of the 1950s another ramification started to appear, private health insurance, first via the "self-managed" model, i.e. health insurance organized by large private or state-owned companies for their employees and, in a few cases, their relatives (Rodrigues, Santos, 2011). As of the 1960s, private healthcare started to be organized into "group medicine", better known as "health plan" companies (Bahia et al., 2005). These were companies that sold health insurance schemes, mainly to groups of employees from a given company. The first medical cooperatives also appeared in the 1960s, first targeting individuals and their families. In the 1980s the growth of the market attracted companies from the financial sector per se – insurance companies –, some of which were linked to large retail banks (Rodrigues, Santos, 2011). All these different companies keen to make a profit from private health insurance constituted another market segment that bought the services provided by private healthcare providers, giving them alternative customers from their existing public sector buyers. Thus the private sector became subdivided into the insurance business, acquiring healthcare services, and the service provision area, selling such services.

Brazilian legislation calls this sector "supplementary" (Brasil, 1998), as opposed to the "complementary" sector, which is defined by article 199, paragraph 1 of the Federal Constitution, as the sector that provides services for SUS: "private institutions may participate in a complementary manner." The supplementary sector therefore encompasses the private sector that has no direct ties with SUS; its transactions are between customers, private health insurance companies, and private healthcare providers. However, this term is very specific to the Brazilian reality, because around the world the concept of private health insurance is used, which seems a more fitting description of the nature of the business (Santos, 2009, p.12). Although Brazilian legislation concerns basically "health plan" operators (Brasil, 1998; 2000) and their interactions with their consumers and only incidentally service providers, these three elements jointly comprise what is called the Brazilian supplementary health market. In June 2013 there were 49,231,643 insureds, or "beneficiaries", of private health insurance in the country (ANS, s.d.a).

Municipalization of services

Since the Federal Constitution there has been a clear intent to decentralize public healthcare services to the municipal level, because one of the local government competencies set forth in article 30, item VII is to "provide, with the technical and financial cooperation of the Union and the State, healthcare services for the population." Law no.8,080/1990 (Brasil, 1990) is even more explicit, establishing in article 7, item IX, sub-item a, "emphasis on the decentralization of services to municipalities." Basic Operating Standards no.1/1993 (Brasil, 1993) and no.1/1996 (Brasil, 1996) created the mechanisms by which the administration and funding of healthcare services and actions would be delegated, promoting a radical transfer of public services to the municipal sphere of government. SUS is the only public health system to be managed in such a way. Public health systems in other countries are organized regionally and have local sanitation authorities that administrate their own budgets and plan, organize and control all the services offered in their territory. Examples of such systems can be found in Canada, Cuba, Spain, France, Italy, Portugal and the United Kingdom (Rodrigues, Santos, 2011, p.65).

The idea of decentralizing to municipal level is based on the initial belief that this would encourage greater participation of society in health policies given the closer proximity of municipal governments to citizens, who would then have greater influence over the government. This belief can be seen, for instance, in a document published by Centro Brasileiro de Estudos de Saúde (Cebes) in 1980, which saw in decentralization the primary goal of "expanding and facilitating the authentic participation of the people at all levels and stages of health policy" (cited in Peres, 2002, p.88). Along the same lines, Basic Operating Standard no.1/1993 states that "SUS ... is oriented by the guidelines of the political and administrative decentralization of healthcare services and actions and should be subject to the control of society" (Brasil, 1993). Decentralization and participation were treated as two sides of the same coin: the democratization of health policies. This argument failed to take into account either the demographics of most Brazilian municipalities, whose populations were too small to merit a complete health system providing care of different levels of complexity, or the fact that Brazil's local authorities have traditionally constituted the representation base for private interests linked to land ownership and the domination of oligarchs as far back as colonial times, passing through the period of *coronelismo* during the First Republic and remaining, albeit somewhat debilitated, to this day.

Most Brazilian municipalities have a small population: 70.5% have fewer than twenty thousand inhabitants and 89.4% have a population of up to fifty thousand (Rodrigues, Santos, 2011, p.104). The smaller municipalities are entirely rural, and their economies and social life revolve around farming and livestock activities, whose supplies and sales are centered in their towns. Neither this group nor the second group – of twenty thousand to fifty thousand inhabitants – has a large enough population to justify the existence of secondary (specialized outpatient) or tertiary (hospitals) healthcare provision. This reality was not considered in the haste to decentralize the management of SUS; the Basic Operating Standards from the 1990s enabled and encouraged small municipalities to opt for the "full management of the health system" as if they had the means to do so. As they cannot afford to have secondary or tertiary

services, these have to be shared with neighboring municipalities, which is administratively complex and also has political drawbacks.

As already mentioned, the decision to manage healthcare services at the municipal level immediately hampered the organization of the service network along regional lines. Although article 7, item IX, sub-items a and b of law no.8,080/1990 establishes the "regionalization and hierarchization of the healthcare network" alongside an "emphasis on the decentralization of services to municipalities," neither the financial resources nor the network of services are managed on a regional level (Brasil, 1990). Health regions in Brazil do not even have their own managers, but just a Regional Inter-Managerial Commission (Brasil, 2011), a collegial body formed by the municipalities involved. As some health regions have a great number of municipalities, it is not always easy to reach a consensus when decisions have to be made concerning the service network. Until the publication of decree no.7,508/2011 (Brasil, 2011), which regulates law no.8,080/1990, Healthcare Operating Standards no.1/2001 and no.1/2002 (Brasil, 2001, 2002), and the Pact for Health (Brasil, 2006), designed to organize the SUS service network, states could be subdivided into health macro-regions or micro-regions. The decree defines a "region" as an "unbroken geographical space constituted by groups of adjacent municipalities" (Brasil, 2011, article 1). Each such region must contain at least the following healthcare services and actions: primary healthcare, emergency, psychosocial care, specialized outpatient care, inpatient care, and disease surveillance (article 5). What have prevailed thus far, however, are regions defined according to previous ministerial directives.

The way the regionalization of healthcare has come about in Brazil means that there are a great many municipalities in each health region. The situation in Minas Gerais, the state with the highest number of municipalities in the country (853), illustrates this well. The macro-region of Central Minas Gerais, which includes the state capital of Belo Horizonte, encompasses 102 municipalities and over six million inhabitants (Santos, 2013, p.74). The situation is no different in the 77 micro-regions in the state: the largest (Belo Horizonte, Caetés and Nova Lima), made up of 13 municipalities, had 3.2 million inhabitants in 2012. The micro-region with the largest number of municipalities in the state (Pouso Alegre) had 33 in all (Brasil, s.d.b). It is obviously hard to reach consistent, mutually beneficial decisions in regions with so many municipalities, resulting in a veritable Lernaia Hydra[6] for which no solution has been found.

However, the difficulty in successfully reaching mutually beneficial decisions does not only have to do with the number of municipalities, but with the fact that the municipality constitutes the basis for the whole political and electoral system of the country. In a system of this kind, competition is naturally fostered between local authorities, since mayors and local councilors aspire to becoming state or federal congressmen or even to taking higher political positions such as senators or governors, but to do so they have to compete for votes in neighboring municipalities. Decisions about the location and even the provision of healthcare services therefore tend to be politicized because of the very way the Brazilian political and electoral system is organized. In an attempt to shed light on this very real problem, part of the literature on SUS has adopted the formulas of "cooperative federalism" (Dourado, Elias, 2011; Gil, Licht, Santos, 2006) or "cooperative regionalization" (Pestana, Mendes, 2004), as opposed to the aforementioned competitive federalism (Franzese, Abrucio, 2009). According

to these alternative formulas, the organization of SUS favors cooperation between entities of the federation, especially neighboring municipalities, for the provision of services of common interest in the area of health, as set forth in article 23 of the Constitution, albeit never regulated. The existence of strong competition between entities of the federation does not, however, enable one to say that these formulas have held sway, as other authors have been at pains to note (Viana, Lima, Oliveira, 2002).

Another argument worth mentioning is the fact that as most Brazilian municipalities are so small, their political power is normally concentrated in the hands of a small minority. In fact, since colonial times, local power has been at the service of large rural landowners, sustaining the phenomenon of *coronelismo*, built on the relics of the old National Guard created in imperial times (Izecksohn, 2009, p.403), and the policy of the governors in the First Republic (1889-1930), where elections and the appointment of the main political positions were totally controlled by local ruling individuals (Leal, 1997; Faoro, 2001). Although *coronelismo* is a thing of the past, its scars can be seen to this day, especially in towns in the countryside where there is less social organization and the full exercise of citizenship is non-existent. Local power in Brazil, and not just this, is still marked by features of *coronelismo*, such as *mandonismo* (authoritarian control), favoritism, nepotism, and clientelism, the latter being when the needs of the poorer sectors of society are met in the form of political favors given in exchange for votes at election time. For Carvalho (1997), *mandonismo* and clientelism have both always been part of the Brazilian political scene, but they each have their own course of action. While *mandonismo* has tended to diminish as society has become more organized, clientelism varies in intensity between political partners and over time, but still remains very present in all forms of society, whether they are large urban metropolises or small rural towns. Under such circumstances, it is far harder for citizenship, not to mention social participation, to be exercised in the smaller municipalities of Brazil, which are the majority in the country.

Final considerations

This investigation of the political challenges facing the consolidation of SUS was based on an analysis of the changes seen in the national and international scenario in the late 1970s and 1980s. Many of the elements that comprised those scenarios have undergone profound change in the last five years. Neoliberal ideas and policies have lost much of their strength and appeal since they led the world to one of the most serious economic and financial crises of capitalism in 2008-2009. The power of the USA, still unequalled militarily, is slipping from the decisive role it played after the breakdown of the socialist bloc in Europe. One of the unforeseen consequences of its efforts to regain its hegemony in the 1980s and 1990s was the emergence of China as the world's second largest economy and the reconstruction of part of the power and influence of the USSR in Vladimir Putin's Russia. Both countries lead a new military bloc, the Shanghai Cooperation Organization, created in 2001, and have systematically blocked American attempts to approve military interventions in countries like Syria and Iran in the UN Security Council. It seems that the world stage again has multi-power politics, which was one of the cornerstones for

Keynesian economic policies and the development of welfare states in many countries. This circumstance could foster the emergence of new spaces for broad-based social policies in the future, and the recent decision made by China, the world's most populous nation, to broaden the reach of its social policies in its 2011-2015 five-year plan could indicate just such a trend (Trevisan, 7 mar. 2011).

However, the economies of the European Union (EU) and the USA are still in a relatively fragile state and marked by principles and policies that derive from neoliberal thinking. The EU's economic difficulties certainly do not bode well for the future of its social policies, although no clear reduction in this area has been seen. In the center of the capitalist system, however, economic difficulties have accelerated the reduction of inequalities between the center and the periphery as a function of the economic growth of peripheral nations like China and India, with major impacts mainly in Asia and Africa, helping to alter the balance of world power. What we can point to is the fact that first of all the unipolar world that emerged after the USA reasserted its hegemony is now facing profound change. There is a strong trend not only towards a return of multipolar politics, but also of a more powerful voice for peripheral nations. Secondly, it is important to stress that the loss of importance of neoliberalism as a founding idea has enabled many nation-States to bolster their autonomy. The growth of the economies in China and India, the two most populous countries in the world, is the clearest indicator of this, for in both countries this growth has been coordinated by the respective States.

Brazil is also undergoing major change domestically. The biggest is without doubt the end of the stranglehold of foreign debt, which now has a relatively limited weight and is mostly made up of private debt. From major debtor, Brazil has now become one of the world's most important creditors, holding hundreds of billion dollars in US Treasury bonds. This means on the one hand that the current scenario is no longer marked by structural adjustment policies, which restricted the spending needed to finance the social democratic policies established by the 1988 Constitution; the increased social spending mentioned earlier is a clear indicator of this fact. However, Brazil's macroeconomic policies are not yet entirely free of neoliberal thinking, and its public investments are still very low, despite its huge international reserves. Brazil has not followed the same path as India and China, which have used part of their reserves to modernize their infrastructure.

Neoliberal thinking still influences Brazil's social policies in general and SUS in particular, albeit in different ways. The choice of targeted policies has limited the funds available for universal policies, as mentioned earlier, with healthcare being one of the main losers. While federal spending on targeted welfare policies grew over 500% between 2000 and 2011, social welfare expenditure grew by just 190.5%, education by 202.9%, and health by just 153.4% (Brasil, s.d.c). This suggests that the country is moving worryingly away from the ideas behind its 1988 Constitution, and this is something that, at the very least, deserves serious discussion, because as the proportion of old people rises, more and more funds will be needed to finance their pensions and healthcare. Meanwhile, there are a growing number of initiatives to introduce the private administration of SUS, rather than strengthening the managerial power of the State, required to sustain public interest in the area. While the State is visibly weakened in the management of the public health system, private management techniques

and concepts are increasingly being adopted, which are unlikely to serve the needs of the public and democracy in an area of such importance to society.

I have also drawn attention to the limited support for SUS amongst workers, resulting from very particular, complex historical circumstances. The challenge of getting workers to see the importance of public healthcare services and policies has yet to be overcome. Even if private health insurance does not assure coverage of healthcare services when they are most critical in a person's life – in old age – access to private health insurance remains one of the top priorities for workers. The task of attracting the main leaders of trade unions to the defense and strengthening of the public health system is one of the great political challenges facing the future of SUS.

Findings solutions for the competition between the public and private health sectors constitutes the greatest challenge facing the consolidation of SUS at the present time. Not only does Brazil's private health sector count on the widespread acceptance of the population, it is very large and moves massive volumes of resources. The increasing adoption of private administration for public health facilities in different parts of the country could further entrench the logic and prestige of the market within the public sector, leaving the values and even the meaning of public administration in an ever weaker state.

The fragmentation of the SUS service network into thousands of municipalities, which until recently was seen as an advantage of the system and capable of ensuring its democratic administration, is increasingly coming under fire. The text of decree no.7,508/2011 strongly suggests that there should be an inversion in the Ministry of Health's position towards giving state governments a more important role in developing and administrating a regionalized network of public healthcare services and actions. In article 30, it "links" the functioning of regional inter-managerial commission to the state departments of health (Brasil, 2011). However, it is no easy task to revert the decentralization of the administration of the system to municipal level introduced in the 1990s. There are powerful political institutions and interests at play that will block any such move, such as the municipal movement and the political and electoral system, which serves the interests of local power. Furthermore, the creation of public regional administrators for SUS would involve reviewing the federative pact. Up to what point would the Union be willing, for instance, to allow states to take on more effective power in the administration of SUS, as many of them are already tending towards? After all, we cannot forget that ideas that support a more active role for the Union in the regional administration of the system tend to be foiled by the very nature of the Brazilian federation.

NOTES

[1] For Esping-Andersen, the main explanation behind the structure of social welfare systems is the political ideologies that give rise to them and determine the way they are organized. He therefore classifies welfare states or systems into three basic kinds: liberal, conservative and social democratic. The liberal model is based on the ideology of the market, and makes it the main supplier of services for society, such that public policies become secondary, geared mainly towards groups that are unable to gain access to the social services existing on the market. The beneficiaries of public policies must be identified and defined by objective measures, such as very low income or skin color. The conservative system, which dates back to Bismarck's Germany, came in response to the challenge posed by Marxism. It proposes to divide beneficiaries into different groups according to the nature of their economic activity, to separate the management of services by institutes or funds administrated by representatives of the employers and employees; and to have mandatory financial

contributions for both employers and employees, withheld at source. Social-democratic systems are based on the idea of equality and universality of access to social policies and services, which should be of a public nature, and are funded by the whole of society by means of state taxation, in the understanding that social policies and services constitute basic rights of all citizens.

[2] The size of the private health sector can be evaluated by taking into consideration: (a) the size of the Brazilian economy – according to World Bank data, accessed February 23, 2014, Brazil was the world's seventh largest economy in 2010, with a GDP of around 2.14 trillion dollars; (b) public health coverage in countries whose economies are larger than Brazil's (in descending order: USA, China, Japan, Germany, France, UK) – according to Organization for Economic Cooperation and Development (OECD) data, except for the US, where in 2009 coverage of public healthcare services was just 26%, and China, on which the OECD provides no data, all the other countries have public service coverage of between 89% (Germany) and 100% (all the others) (OECD, 2011); (c) public health spending compared to private health spending in the seven largest economies of the world – according to World Health Organization data (WHO, 2013, p.132-137), Brazil's total health spending corresponded to 9% of its GDP in 2010, i.e. around US$193 billion, 53% of which was private spending and 47% was public spending.

[3] Paragraph 12 of article 201 of the Constitution states that the "law shall provide for a special system for the welfare inclusion of low-income workers, assuring them access to benefits worth a minimum wage, except for pensions based on number of qualifying years," (Constituição, 2011) which effectively made access to social security universal.

[4] There are currently 32 political parties in Brazil.

[5] The government's social functions are: social security, health, social welfare, education, labor, urban planning, citizens' rights, culture, sanitation, and housing (Brasil, s.d.c).

[6] An animal from Greek mythology with a dragon's body and seven or nine serpents' heads, depending on the version.

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